

IMPROVING THE HEALTH OF GUATEMALA'S MOST VULNERABLE POPULATION: MIGRANT WOMEN AND CHILDREN IN THE BOCA COSTA REGION OF SOUTHWESTERN GUATEMALA

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ACRONYMS

ADISS	Asociación de Desarrollo Integral Servicios Social (an NGO)
AMNE	Essential Maternal and Newborn Care
APAES	an NGO, Association for the Assistance of PLWA
CA	Cooperating Agency
CBDA	Community Based Distribution Agent
CS	Child Survival
DIP	Detailed Implementation Plan
ETANA	National Technical Advisory Committee for IMCI
GTI	Interagency Technical Group
HU	Health Unit
IMCI	Integrated Management of Childhood Illness
IGSS	Guatemala Social Security Institute
JHPIEGO	John Hopkins Program of International Education for Gynecology
MOH	Ministry of Health
RH	Reproductive Health
TBAs	Traditional Birth Attendants

INTRODUCTION

This report summarizes the achievements of the first program year of Project HOPE CS-17 extension project in the Boca Costa of Guatemala and four highland municipalities in the South West of Guatemala (see map, Attachment 1).

Project HOPE was awarded a four-year extension to extend and expand its successful CS-13 project, aimed at improving the health of women and children residing in or migrating to coffee plantations in the Boca Costa region of southwestern Guatemala. The CS-13 project provided benefits for more than 200,000 migrant and resident children and women of reproductive health on about 150 coffee plantations in the departments of San Marcos (SM), Quetzaltenango (Q), Suchitepequez (Su), Retalhuleu (R), and Sololá (So). The extension project is planning to expand the activities, adding 100 plantations and 4 municipalities within these five departments. The current project will provide targeted assistance to some of the municipalities of origin of the migrant – as well as increase the program's reproductive health focus and strengthening overall sustainability. As with the CS-13 sites, the new plantations are all privately owned, large enough to employ migrant families during the harvest season, and have, sufficient resident and migrant population to warrant the establishment of a health unit and training a health promoter.

Prior to the CS-13 project, private plantation residents and migrants had virtually no access to health services on site; government agencies did not plan annually for the influx of migrants and allocate additional resources; and quality of care and community outreach was poor. Project HOPE undertook to strengthen the technical and management capacity of these agencies, as well as the Guatemalan organization of coffee growers (ANACAFÉ), and local NGOs. Project HOPE's aim was to increase the access of the target population to primary care and preventive activities at the health facility level and on the plantations, to improve the quality of such care, and to increase community demand in clinical and preventive care. The project's direct, intended results included establishment of 150 plantation-based health units, institutional strengthening of Health Area Councils, training of health promoters and traditional birth attendants, establishment of teams of master trainers, and health messages developed for and transmitted by radio stations. In addition, the project has had unanticipated benefits, e.g., a department assuming responsibility for training additional health facility staff, plantations assuming responsibility for improving living conditions for migrant families, and plantations contracting on their own with private health professionals to assist promoters.

The challenges – which are being addressed by the current extension – are considerable. As indicated, there are a substantial number of plantations in the departments that are not currently being served. Only child and maternal care was addressed by the CS-XIII project, while increased emphasis will be placed on child spacing and STIs, including HIV/AIDS, in the current project. Limited funds from the Summit Foundation enabled HOPE to explore new strategies for family planning and reproductive health on plantations in two districts in Quetzaltenango that will inform the project as RH activities are scaled up. Language barriers on the plantations create communications problems that argue for strengthening health education in the migrants' communities of origin. A dependable supply of essential medications must be assured at the health units. And local organizations require continued strengthening, so that they have the capacity to sustain the project activities.

The current extension will reach approximately 330,000 beneficiaries, including 162,304 children under five and 171,959 women of reproductive age, and provide substantial benefits to migrants and residents in the target area through capacity building of the MOH and other partner agencies.

The overall goal of the extension, as with the CS-13 project, is to provide better health in a sustainable manner for women and children residing in or migrating to coffee plantations in the Guatemala's Boca Costa Region. This will be accomplished by achieving tripartite collaboration among employers, government, and NGOs. In terms of strategic approach, the focus will be exclusively on building the capacity of the project's local public and private partners by strengthening the activities they are currently engaged in or have been designated to be engaged in – planning, services delivery, training and supervision, and outreach and collaboration with the communities. Project HOPE itself will not engage in the delivery of services to residents or migrants in the target area.

The project provides capacity-building support to its partner agencies for the following interventions: Immunization (5% level of effort), nutrition and breastfeeding (20%), acute respiratory infection (15%), diarrhea (10%), malaria (5%), maternal and newborn care (20%), child spacing (15%), and HIV/AIDS/STIs (10%). The project will provide technical, management, financial, research, monitoring, and evaluation support to its local partners, who are directly responsible for carrying out the interventions.

Project partners are the MOH, IGSS (Guatemala Social Security), 29 municipalities, Anacafé, local NGOs, and 250 coffee plantations. (Four new municipalities and 100 new coffee plantations were added). Four new NGO partners will collaborate with the project in the new municipalities. HOPE will also collaborate with the Ministry of Education and USAID cooperating agencies (CAs) in certain interventions. In disseminating health messages in migrants' communities of origin, the project will engage a broad array of partners including political and cultural organizations, churches, indigenous women's groups, cooperatives, teacher organizations, auxiliary mayors, and community leaders.

A. What are the main accomplishments of the program?

The primary project achievements include:

1. Strengthening of Inter-Institutional Coordination

Inter-institutional coordination, involving the Ministry of Health (MOH), the Guatemala Social Security Institute (IGSS), Anacafé/Funrural, the owners and administrators of coffee plantations, the MNH project managed by JHPIEGO, and other organizations working in the target area, is one of the most important strategy of the project. This is important to build local capacity and promote the sustainability of the project activities. During the first project year, Project HOPE conducted four workshops and eight planning/work meetings, with the participation of the technical program managers of the partner organizations. A total of 72 staff members from department, district and health facility partner agencies participated in these meetings. The

meetings defined roles and responsibilities for technical assistance, supervision and follow-up to project activities, outreach to community volunteers (promoters, traditional birth attendants [TBAs]) and the population residing on the coffee plantations, as well as the special health campaigns for migrant women, migrant children, and the resident population. Formal agreements and letters of understanding were reviewed, the project proposal presented and discussed, and the detailed implementation plan developed.

Coordination meetings with the plantation owners and administrators were conducted via the municipal health staff, and with support from the HOPE personnel four meetings, two in San Marcos and two in Suchitepeque, took place with four networks of plantation owners. These meetings were called by Anacafe's Funrural NGO, rather than by Project HOPE, to promote their ownership of this activity for long-term sustainability.

2. Strengthening of the Training System

a) Training

At project onset, Project HOPE upgraded the technical knowledge and skills of its own CS staff (14 individuals) with four workshops covering the following interventions:

- ❑ Reproductive Health: Maternal and Neonatal Care, family planning and HIV/AIDS with the support from JHPIEGO's MNH staff and the NGO APAES (an NGO, Association for the Assistance of PLWA).
- ❑ Facility IMCI and community-IMCI/AINMC with the support of the MOH technical team; and the
- ❑ Local situational analysis (*sala situacional*) with support from the epidemiologist of the MOH Quetzaltenango.

These training activities were important, given Project HOPE role as trainer-of-trainer and facilitator of trainings for partner agency staff and community volunteers.

Project HOPE staff has also benefited from the technical input of the Regional Health Education Specialist, Ms. Marta Arce. Ms. Arce conducted two workshops for the staff to improve training approaches and skills, covering adult education techniques, principles of teaching and learning, the profile of facilitators, and the use of standardized approaches and methodologies to plan, implement, and monitor high quality training activities. Given the importance of training in the project, Project HOPE also decided to hire a local health education specialist to strengthen the training activities and achieve a better transfer of knowledge and skills in the trainees.

Project HOPE trainers belong to the team of identified national trainers for IMCI/AINMC and the following working groups:

- ❑ Interagency Technical Group (GTI) – this is a group consisting of representatives of the MOH and NGOs that experience in community mobilization and participation. The function of this committee include:
 - development, review, and validation of education and training materials;

- development, review, and validation of promotional materials for the various components of this strategy; and
 - review and validation of health messages developed for IMCI/AINMC and family planning.
- National Technical Advisory Committee for IMCI (ETANA) – this committee consists of representatives of the MOH and NGOs and provides oversight to the national implementation of IMCI, including monitoring of the implementation status, review and validation of all materials used for training at the various levels, and validation of all materials used by the health districts in the implementation of IMCI/AINMC.

Project HOPE continues to work with the master trainer groups of the MOH and the IGSS that were trained in child health, maternal care, and adult teaching methodologies in the CS-13 project and is assisting its local partners in developing master trainers in the new technical areas, with the objective of sustainably transferring all training responsibilities to the partner agencies. Project HOPE uses the following cascade approach to training: HOPE trainers train the master trainer group at the department level. These are responsible for the training of the municipal training team, which in turn assume the responsibility for training local staff and volunteers. Project HOPE staff assist the municipal training teams in replicating training activities, as needed and feasible to monitor the quality of the training activities.

Together with JHPIEGO's MNH staff, Project HOPE has assisted in the formation and strengthening of municipal trainers in reproductive health to support the national strategy of Essential Maternal and Newborn Care (AMNE). A performance-based training approach is used to cover the reproductive health components of maternal care, family planning, sexually transmitted infections (STIs), HIV/AIDS, and infection prevention. Project HOPE and JHPIEGO have also participated in the baseline assessment of the quality of RH services and planning of improvements based on the identified needs. Training curricula are also based on the identified training needs of the providers.

To complement the CS project and with additional funding of the Compton Foundation, additional activities have been implemented to strengthen the technical knowledge competence of the MOH and IGSS staff in the district of Chicacao, Suchitepequez and to implement a community-based distribution system of contraceptives. Sixty promoters and TBAs have been trained in the distribution of family planning methods, in the counseling of couples, and in health education for resident and migrant populations. This activity is being implementing in coordination with APROFAM (Guatemala's IPPF affiliate agency) and has received financial support from the Compton Foundation. APROFAM has shared its training approach for community-based distributors, its education materials, and health information system, has procured the methods, and participates in the supervision of the CBDAs together with the MOH, IGSS, and HOPE. Project HOPE has conducted the training activities and funded the reproduction of training materials.

The RH training activities have also benefited from the inputs of Project HOPE's Regional Health Education Specialist and strengthened the quality of training Project HOPE staff provide to their partners. Table 1 below provides a summary of training activities.

Table 1. Training Activities during Year 1

DEPARTMENT LEVEL	IMCI	AINMC	RH	PARTNER AGENCY
San Marcos	2	22 (1 trainer team/s)	10 (1 trainer team/s) 2	MOH FUNRURAL/ANACAFE
Suchitepequez	11 (1 trainer team/s)			MOH IGSS
Quetzaltenango	11 (1 trainer team/s) 6 (1 trainer team/s) 10	25 (2 trainer team/s)	12 (1 trainer team/s)	MOH Hilario Galindo Hospital ProRedes
MUNICIPAL LEVEL				
San Marcos		10 (1 course)		MOH
Suchitepequez	18 (1 course)		10 (1 course)	MOH
Quetzaltenango	122 (10 courses)			MOH
COMMUNITY LEVEL				
Technical and financial support to districts for promoter training	429 promoters		442 TBAs	29 MOH districts

b) Training Materials

Project HOPE provides technical and financial support, as well as supplies and education materials for the education and training activities. Included are also materials for mothers and basic health messages in different Mayan languages and Spanish, which are transmitted by 32 radio stations during times, paid for by the MOH. The radio messages were initially tested via loudspeakers on the plantations.

Under an effort supported by GlaxoSmithKline, Project HOPE has also developed Mother Reminder Materials to complement existing national IMCI/IEC activities. These materials are provided to the families to help them recognize danger signs of common childhood illnesses and to tell them when to seek care from trained providers and how to manage the sick children at home. Project HOPE conducted the formative research in the Department of San Marcos with ladino and indigenous mothers in highland communities and developed and validated the materials with the same populations. The result is a calendar for 2003 that on each page has messages on how to prevent an illness, what to do if the child becomes sick and displays danger signs, and where to seek care. The calendar takes into account seasonal disease patterns. The community volunteers who will be trained in advising mothers in their use will disseminate the calendars to the mothers.

Many of the education and training materials used by the MOH for IMCI/AINMC were adapted and reproduced. Attachment 2 provides a listing of all training and education materials used by the project.

c) Supervision and Follow-Up

Project HOPE's responsibility for supervision and follow-up consists in assisting the training teams of its local partners in monitoring the quality of training activities, pre- and post-test evaluations, and in monitoring the quality of service delivery by assessing the on-the-job performance of the providers. The Project HOPE team has developed a series of tools based on tools used by the MOH to monitor the performance of providers using IMCI. These instruments were applied in five municipalities of San Marcos and Suchitepequez in December 2002. One tool rated the provider performance, another the health facilities. The performance of 60% of providers was judged as acceptable, 20% good, and 20% as sub-standard. With respect to the five health facilities, two were in excellent condition for implementing IMCI, two were judged acceptable, and one as good. The findings of the assessment exercise indicate that all five health centers were using the IMCI strategy. The main constraints to the application are time and lack of resources.

With respect to community-IMCI/AINMC, activities have not been monitored yet, because this IMCI component is in the introductory stage of training departmental facilitators and NGO trainer teams. Community activities will commence in 2003.

In addition to supervision and follow-up of the training activities, the Project HOPE field supervisor also provides supervision and follow-up to project-related activities at the municipal and community level with his colleagues from the partner agencies, with a particular emphasis on providing support to activities on the coffee plantations. For these supervisory visits, he uses supervision tools developed by Project HOPE with input from the local partners.

3. Involvement of the Owners and Administrators of the Coffee Plantations

The project is motivating the involvement of plantation owners and administrators through bi-monthly meetings. In these meetings, the participants are informed about the services that have been provided by the plantation health units. It is emphasized that this increases the productivity of the mothers and reduces emergency transport costs of the plantations for transferring critically ill children to hospitals that are far away. These meetings have helped to maintain the support of the owners and administrators for paying stipends to the promoters, improve the infrastructure of the health unit, purchase some equipment or medications to treat patients, making it possible that promoters attend the monthly supervision meetings at the closest health center and helping with transport, and help assure that the health unit is open during hours when migrants can use them (evening and night, due to the long work days). Additional support for maintaining the health units is derived from the training and education activities at the health units, the distribution of education materials, and the follow-up and supervision of plantation promoters. There are also meetings every three months with MOH, IGSS, and FUNRURAL staff, and the plantation owner networks, review the work of the plantation health units, find solutions to constraints encountered, and to identify plantations that have graduated from the program, based on the ability to respond to the local needs.

4. Other Project Achievements

a) Operations Research

The project conducted a study about the knowledge of mothers after they have seen a provider with a sick child under five years of age, their attitudes and practices following the consultation, their compliance with the home treatment, and their return for a scheduled follow-up visit. The study was conducted in three health centers and 10 plantation health units in the municipalities of El Tumbador, San Pablo, and Malacatan in the department of San Marcos during December 2002 (see report in Attachment 3).

The formative research for the development of the mother reminder tools on danger signs and care-seeking behaviors was conducted in four communities of Malacatan, San Marcos.

In September – October 2002, the project conducted a mini-study of the conditions of the plantation health units in the three departments. 127 health units were assessed, taking into account the physical condition of the health unit, the services provided by the promoter, and the level of support for each health unit from the local partners (MOH, IGSS, NGOs).

b) Implementation of Health Units in Plantation Resident Communities

Because of the low prices for coffee on the world market, a number of plantation health units stopped operating. The main reason was because the promoters were let go or because the owner sold the plantation, and twenty promoters had to move to nearby villages. As a result, the project decided to establish health units in the nearby resident communities to take advantage of the already trained promoters and to continue to increase access to basic health services for the population. Twenty such health units were established with promoters continuing to serve as volunteers.

c) Operation of 144 Plantation Health Units Managed by Trained Promoters

In the CS-15 project, Project HOPE assisted the participating coffee plantations to establish a total of 150 plantation-based health units. The promoters staffing these health units were trained in the standard case management of children under five years with ARIs and diarrheal diseases. The responsibility of the local MOH was to re-supply these units monthly with essential drugs, to vaccinate children, and provide supervision and follow-up, including conducting a monthly follow-up meeting for the promoters. Staff of the Suchitepequez IGSS monitor promoters in their target area on a monthly basis, and they conduct health fairs together with MOH staff on the plantations for residents and migrants, particularly during the coffee harvest season. The plantation owners and administrators pay a stipend to the promoter, provide the physical space and furniture for the health unit, and assist the promoters so they can attend the monthly supervision meetings at the MOH health center. Project HOPE provides technical and financial support for the training of the promoters and the monthly supervision meetings, training materials, health education and promotion materials, and monitoring of promoter performance.

Because of the coffee crisis mentioned above, there are currently 144 health units supported by the CS-17 project, 124 from the CS-15 project and 20 new ones that were moved into nearby resident communities.

An assessment of 144 health units in September – October 2002 (17 units were not assessed because there was no promoter) produced the following findings:

- 86 of the promoters are volunteers; 19 receive a monthly salary, specifically for working in the health unit; and 24 receive a salary for working in the health unit and for doing other work on the plantation;
- With respect to case management, 90% (113) of the promoters classified and treated cases appropriately, but less than 50% counseled adequately and provided the necessary follow-up.
- 60% (76) of the promoters conduct health education sessions for mother groups, and 104 (80%) of the promoters attend their monthly supervision and continuing education meetings at the closest health center.
- 82.3% of the promoters report to the health center about their activities (cases managed) on a monthly basis.
- Referral rates were low. Only 46 health units referred an average of three cases per month.
- Half of the promoters see about 20 cases per month of plantation residents, but more cases during the coffee harvest and the arrival of the migrant families.
- More than 75% of the promoters confirmed that they participate in health promotion and health fair activities, that they check on the sanitary conditions on the plantation, and that they visit the *galeras* (barracks where the migrant families are housed).
- With respect to essential medications, 30% (38) plantation health units had a sufficient drug supply, 42% insufficient, and 27% (35) had no medications.¹
- Health units are open on the average for three hours; 74 units are open every day; 17, 2 or 3 times per week, and 34 on demand.
- With respect to supervision by the local partners, frequency of supervision was as follows during the three months preceding the assessment:
 - 3 times: 66 units
 - 2 times: 40 units
 - once: 19 units
- Supply with medications was as follows in the three months preceding the assessment:
 - 3 times: 3 units
 - 2 times: 19 units
 - once: 55 units
 - none: 48 units

¹ Facilities with no medications received donated supplies from HOPE; medications procured by the ILO projects; and some from the MOH.

d) Improvement in the Health Services for Migrants

The migrants often come from distant highland communities in the departments of Quiché, San Marcos, Sololá, and Huehuetenango to the Boca Costa. These migrant families are among the poorest families in Guatemala and engage in seasonal labor to gain additional resources to meet their basic needs to survive. They usually have very limited access to health services while on the plantations due to the geographic location of the plantations, and significant cultural, linguistic, and financial barriers. During the coffee season months of September through December, demand for health services in the Boca Costa increases substantially with the arrival of the migrant families. Health fairs conducted by MOH and IGSS staff on the plantations provide prenatal care; health care and immunizations for children under 5 (and TTV for pregnant women); vitamin A supplements and deworming pills; and health education sessions for mothers.

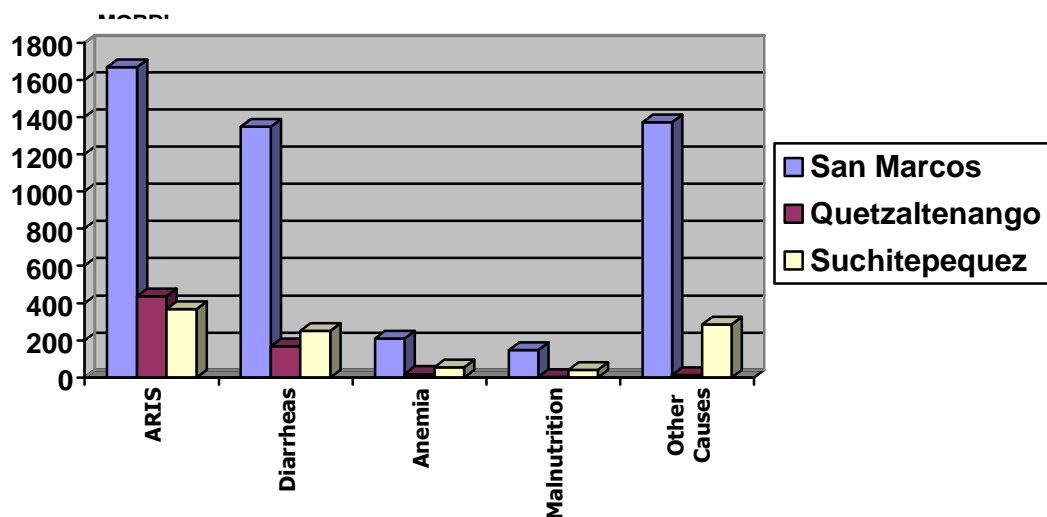
Project HOPE supports these activities of the MOH, IGSS, and local NGOs (Funrural/Anacafe, Intervida, ADISS, the dioceses of San Marcos, and others, and helps to coordinate the bringing together of human resources, materials, vehicles, medications, and other essential supplies.

During the 2002 harvest season, a total of 206 health fairs were conducted in the three departments. 4,798 illnesses treated; 8,899 children under five years of age vaccinated, 210 women provided with a prenatal check, 210 pregnant women received iron supplements, 259 TTV were given, and 1,551 capsules of vitamin A and 1,298 de-worming treatments were provided. The MOH and IGSS were in charge of organizing the plantation health fairs, with support provided by Project HOPE and other agencies.

The following page provides a summary of the health services for the migrant population.

GRAPH 1: CASES OF MORBIDITY SEEN DURING THE HEALTH FAIRS PROVIDED BY MOH PERSONNEL, IGSS AT THE PLANTATION OF THE BOCA COSTA IN THE THREE DEPARTMENTS DURING THE 2002 COFFEE HARVEST.

	ARIs in Children < 5 years		Diarrhea in children < 5 years		Anemia in Children < 5 years		Malnutrition in children < 5 years		Other causes in children < 5 years		TOTAL	%
	#	%	#	%	#	%	#	%	#	%		
San Marcos	1,667	35.1%	1,349	28.4%	208	4.4%	148	3.1%	1,374	29.0%	4,746	100%
Quetzaltenango	435	68.7%	167	26.3%	18	2.8%	1	0.2%	12	1.9%	633	100%
Suchitepéquez	366	36.5%	251	25.1%	55	5.5%	41	4.1%	286	28.6%	999	100%
Total	2,468	38.7%	1,767	27.7%	281	4.4%	190	2.97%	1,672	26.2%	6,378	100%

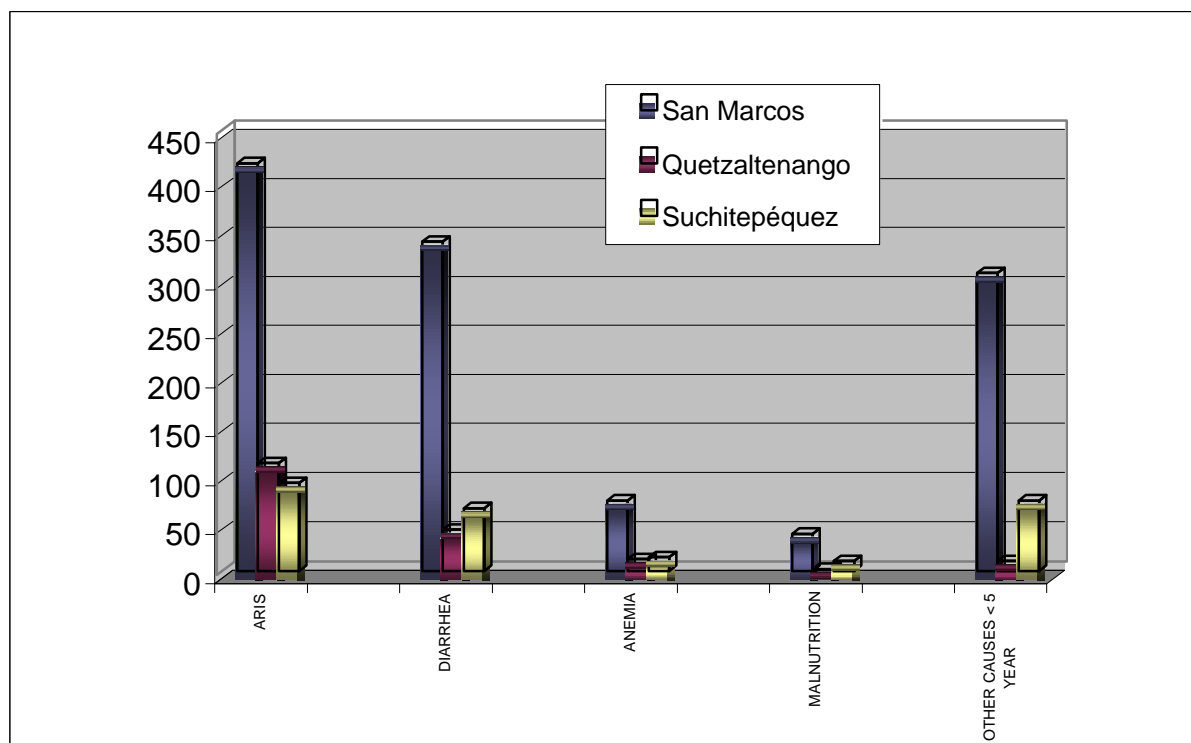


Source: Integral System of Health Manager Information MOH

Graph 1 displays the morbidity of children under five by cause and department. Approximately 75% of the cases seen were children under five years; the remainder was from other age groups. Approximately, three quarters of the cases were from San Marcos which has 82 health units (56.9%), Suchitepequez 27.2% and Quetzaltenango 20.8%. ARIs account for 38.7% and diarrheas for 27% of the cases seen, which is in line with the local epidemiological profile in the target area

GRAPH 2: MORBIDITY OF CHILDREN RESIDENTS <5 YEARS ATTENDED IN 144 HEALTH BASIC UNITS OF THE THREE INTERVENTION DEPARTMENTS (January – December 2002)

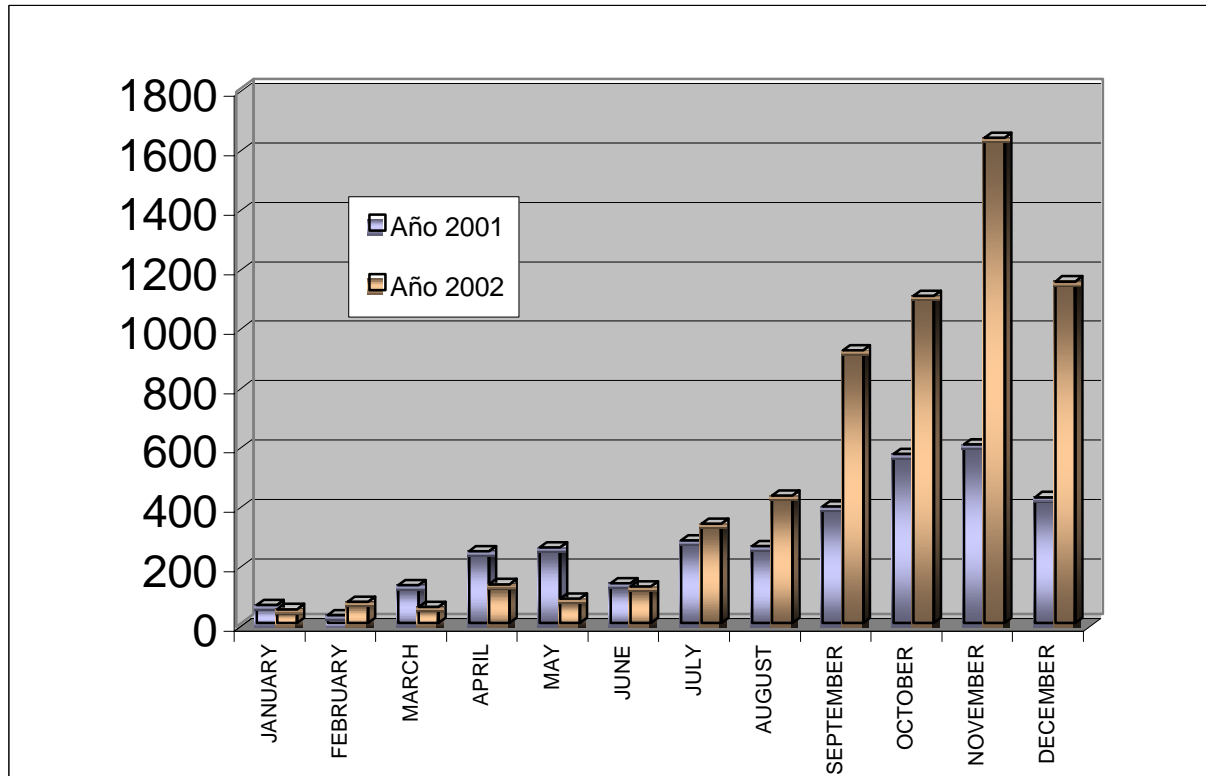
	ARIs in Children < 5 years		Diarrheas in children < 5 years		Anemia in Children < 5 years		Malnutrition in children < 5 years		Other causes in children < 5 years		TOTAL	%
	#	%	#	%	#	%	#	%	#	%		
San Marcos	416	34.5%	336	27.9%	72	6.0%	38	3.2%	304	25.2%	1,206	100%
Quetzaltenango	110	62.5	42	23.8	12	6.8	2	1.13	10	5.68	176	100%
Suchitepéquez	90	36	64	25.6	14	5.6	10	4	72	28.8	250	100%
Total	616	37.7	442	27.8	98	6	50	3.06	426	26.1	1632	100%



Source: Integral System of Health manager information MOH

Graph 2 displays the cases of morbidity in the resident population seen at the plantation health units. 75% of the cases reported were children under five years, and most were cases of ARI or diarrhea. The low number of children with malnutrition or anemia is probably due to the fact that there are still weaknesses in a more integrated assessment of the child. Also, the average number of cases seen by promoters is very small. This may be due to reporting problems and integration of these data into the MOH HIS at the district level. Another factor may be the low emphasis of the MOH on supplying the health units outside of the coffee harvest. Plantation health units with low productivity will be assessed with the MOH district health teams in February 2003 to decide how to proceed with them.

**GRAPH 3: CONSULTS ATTENDED BY MONTH IN THREE DEPARTMENTS OF INTERVENTION FOR CHILD SURVIVAL PROGRAM
2001 - 2002**

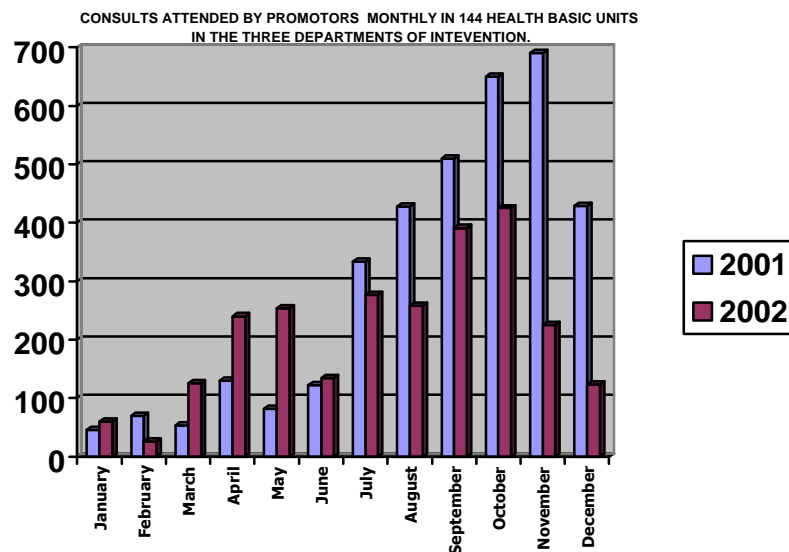


Source: Integral System of Health management information MOH

Graph 3 displays the number of services delivered by month in the last two calendar years. A marked increase can be observed during the coffee harvest when direct services are also delivered by MOH, IGSS and other health providers during health fairs, with the participation of the promoters.

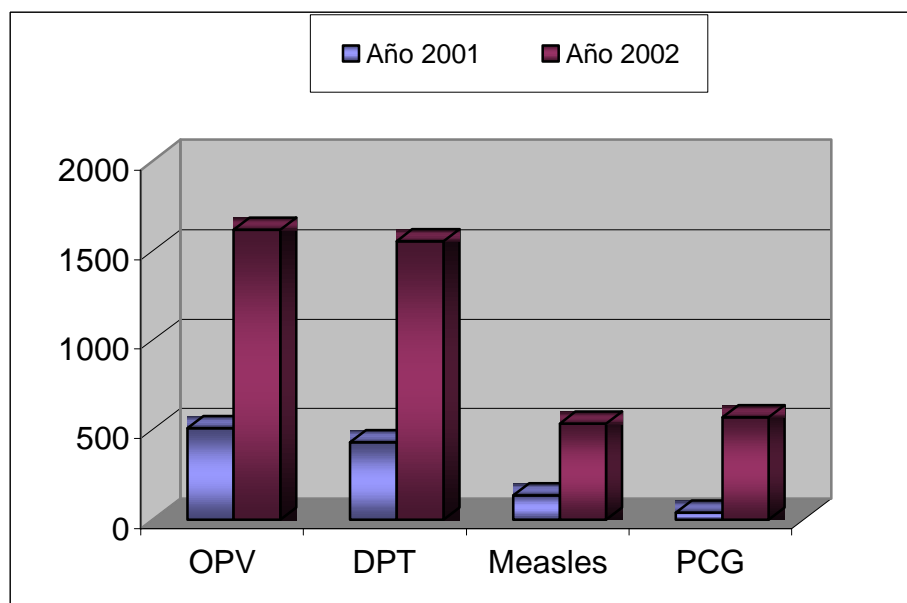
Another factor contributing to lower service utilization rates in 2001 are the low wages paid to the migrant workers due to low world market prices for coffee. This reduced the number of migrant families that traveled to the Boca Costa to pick coffee and reduced demand for health services.

**GRAPH 4: MONTHLY CONSULTS ATTENDED BY PROMOTER
IN 144 BASIC HEALTH UNITS
2001 – 2002**



Graph 4. Total number of services delivered by the plantation health units to residents and migrants in the calendar years 2001 and 2002, In this graph one can observe the attention the promoters give during harvest season as compared to other times.

**GRAPH 5: VACCINATION OF MIGRANT CHILDREN
< 5 YEARS IN THE BOCA COSTA
2001 - 2002**



Graph 5 displays the quantity of vaccinations provided to migrant children under five years of age during the past two harvest seasons by MOH staff during health fairs. More vaccinations were conducted this year due to a greater involvement of MOH staff in this activity and the presence of more migrant families for the coffee harvest.

A.2. What factors have contributed to these accomplishments? What has the program done well?

The factors that have contributing to achieving these results are:

- The existence of a national policy to address migrant family needs;
- The agreements and letters of understanding signed between Project HOPE and its various local partners (three MOH offices, IGSS, Anacafe/Funrural), Project HOPE's overall approach that local activities are the responsibility and are implemented by the MOH and not Project HOPE staff;
- Technical, management, financial, logistic, and other material (e.g., some donated pharmaceuticals) support provided by Project HOPE to its partners;
- The quality of the technical support (training, monitoring and supervision) provided by Project HOPE to its partners;
- The ongoing presence and participation of Project HOPE staff in the bi-monthly departmental health area meetings for planning and coordination purposes.
- The mentoring by Project HOPE staff of its partners at the different levels of implementation;
- The findings from OR and other data shared by Project HOPE with its local partners to increase the impact of the project activities
- The level of commitment and reliability demonstrated by Project HOPE to support the joint activities.

Review of Benchmark Progress:

The strategies utilized in this project are proving to be far reaching. An example is that as a result of the project, the MOH is now requiring the area Health Offices to provide reports on the status of the migrant population. This will ultimately result in the increase of services in the form of medicine, vaccines, health personnel, and specifically targeted to the migrant community.

As a side benefit to the above mentioned outcome, the information systems will improve since the data presently required by the central authorities has to come from plantation and community health units.

Directly at the project level, each of the three health intervention areas has municipal and departmental Master trainers who have been trained in planning, monitoring and evaluation in reproductive and child survival components of health. This will permit the sustainability of the educational process.

The MOH is progressively assuming responsibility to provide the HU's of the plantations with medicines, vaccines, supplies and registrations with administrators and local agencies.

The local agencies of the MOH and of the IGSS are planning the visits to migrants and are requesting the needed supplies to departmental authorities that have so far been very supportive in their efforts. They have also been involved in the supervising of the personnel running the health units and in the monthly community strengthening meetings with plantation owners and administrators.

The training of promoters and midwives is being done by partner agencies.

On the down side, the difficult situation confronting the country today, due to the low prices of coffee, as mentioned, has forced some owners to hold back the trained personnel that ran the HU's or allowed them to continue without pay. This has been a problem since the owners are still paying 25% of the promoters running the health units. Nevertheless, strategies have been implemented to resolve the dilemma in the contingency plan. Also, this problem has not allowed the MOH to comply with its commitment to supply the units with continuous and timely medicines, since the budget since the budgets are continuously suffering cuts and changes in the medicine objective.

Table 2: Project Benchmarks

Indicator	Goal, LOP	To be Achieved in Year 1	Achieved	%
Number of health workers trained (child health and nutrition, community IMCI, AIN-C, reproductive, maternal health)	450	150	284	189
TBAs trained in child health, maternal and reproductive health	1000	200	442	221
Promoters trained in child health, maternal and reproductive health	200	50	60	120
CBDAs trained in child spacing	100	100	45	45
Number of trainers active in 29 municipalities	132	45	55	11
Number of quarterly meetings held with partners to analyze data for decision-making using "sala situacional", LQAS information to adjust project work plan	12	3	0	0
Number of Coffee Growers Networks involved in health initiatives	8	2	4	200%
Number of planning meetings with coffee estate administrators	96	24	5	21
Number of Basic Health Units (HUs) that are active, provide services in a convenient hour : a) HUs inside Coffee estates, b) HUs in communities close to coffee estates	250	170 (20 new)	144 109 (old) 35 (new)	84.7 75 25
Number of visits to Health Units per year by children and mothers during				
a) Coffee harvest season (includes migrants)	12000	5000	1913	38%
b) Remaining of the year (only resident population)	TBD	TBD	1632	
Number of outreach campaigns including one or more of the following activities: growth monitoring and promotion, MN supplementation, immunization, deworming, antenatal care, treatment of acute conditions in coffee plantations	600	200	206	103

Indicator	Goal, LOP	To be Achieved in Year 1	Achieved	%
HUs with adequate inventories of essential supplies (%, based in supervisions)	80	50	35	70
% of resident mothers satisfied with the services provided by HUs [exit interviews]	70%	50%	Study results pending	
% of migrant mothers satisfied with the services provided by HUs [exit interviews]	70%	50%	Study results pending	
Number of supervisions made by MOH staff to HU based providers	6,000	1,000	988	98.8
Percent of monthly meetings at health facilities HU providers attend	80%	40%	43%	107
% of institutional providers performing accordance with IMCI norm [critical areas]	60%	40%	80%	200
% of community-based providers performing accordance with IMCI norm [same]	70%	50%	90%	
Number of municipalities conducting FHA	TBD	TBD	0	0
Number of radio stations broadcasting messages in Mayan languages	15	5 new	32	640
Number of resident children under 2y participating in GMP sessions in selected highland/ Boca Costa communities/ plantations where AIN is being implemented	TBD	TBD	Study results pending	
% of children gaining weight according to the norm in (mini-study)	70%	50%		
Number of mothers groups receiving health education in coffee plantations	200	50	60	120
% of TBAs using clean birth kits, number (mini-study)	75	25	Study pending	
Number of coffee estates with emergency transportation	250	30	30	100
Number of coffee estates providing transportation for health campaigns	250	50	15	30
LQAS monitoring rounds conducted	2/year	2/ year	0	0*
Number of municipalities where HOPE/partners overlap CS interventions with related activities: sanitation, micro credit, food security, low-cost drugs, other	15	3	8	266
Number of plantations allocating financial resources to HUs during that year	150	25	24	96
New funding sources identified for project activities	3	1	0	0

* It was suggested at the DIP review that LQAS may not be appropriate, given random selection issues.

A.3. How is the DIP (including the budget) being used?

The development of the DIP was a joint responsibility of Project HOPE and partner agency staff. Three workshops with a total of 88 MOH staff and one workshop with IGSS staff (14 individuals attending) were conducted to review and adjust the interventions, objectives, activities, and indicators; to define the strategies, and each partners roles and responsibilities; and to discuss how all activities, including training, supervision, follow-up, the HIS, and specific monitoring and evaluation activities would be implemented. The workgroups provided the content, as well as useful recommendations for each section of the DIP.

The DIP provides the foundation for the annual, quarterly, and monthly work plans and the indicators are used for ongoing monitoring of achievements by objective. The DIP has been shared with all Project HOPE staff. The team discusses the barriers and limitations they are encountering in their implementation of activities on a monthly basis. The DIP also provides the basis for quarterly internal technical reports to HOPE Center. The DIP has also been shared with the MOH, IGSS, and Funrural staff, and they also participate in quarterly meetings to review achievements and address barriers and constraints.

No substantive changes have been made to date. However, the feasibility of adding new plantation health units at the rate proposed in the original proposal is a concern, given the low world market prices for coffee (and, as a result, the viability of the Guatemalan coffee industry and the continuing role of seasonal labor to pick the coffee beans). As described earlier, this has led the project to establish some health units in resident communities.

The DIP budget provides a general guidance for the project expenditures and is closely being monitored in the field and at headquarters.

<p>B. What factors have impeded progress towards achievement of the overall goals of the program and what actions are being taken by the program to overcome these constraints?</p>
--

As mentioned in the previous section, the project has worked with fewer plantation health units during the first year (144) than proposed (170). This is due to the economic situation described earlier. Some plantation owners or administrators are not interested to continue with this program, they had to reduce staff and/or seasonal labor, and/or they had to sell their plantation. As a result, the project has proceeded with the alternative outlined in the DIP of establishing some health units in low-access resident communities where there may be high demand for services.

In addition, to address this constraint, Project HOPE continues to strengthen district-level networks of plantation owners and administrators and facilitate meetings every four months with the MOH and IGSS to provide some motivation for the continuing participation of the plantations in this project. In these meetings, activities to benefit the local population are planned; expectations, roles, and responsibilities reviewed, and issues affecting sustainability of the plantation health units discussed. This includes the establishment of local revolving drug funds, involving local committees, and municipal authorities.

Another significant limitation is the fact that economic constraints faced by the government have made it impossible for the MOH to supply the plantation health units regularly with the necessary medications. This de-motivates the plantation owners and administrators, so that sometimes they do not allow the promoters to attend their monthly meetings with the MOH staff at the MOH health center. To try and address this essential issue, Project HOPE is coordinating with other organizations, including Intervida, NGOS that are contracted under the national SIAS program to extend services in the target area, and Project HOPE has also provided donated medication. These measures help to improve the supply situation somewhat. In addition, Project

HOPE's local NGO ADISS is establishing municipal pharmacies and community revolving drug funds. To date, in the Boca Costa region of the department there are 8 established municipal pharmacies and 12 community revolving drug funds that are situated in plantations and nearby communities. Project HOPE is also coordinating with a project funded by the ILO to Eradicate Child Labor which provides essential medications to health facilities in the municipality of Tumbador which is a target area for both the CS and the ILO project.

A further limitation is access to the activity reports of the plantation health units and the migrant coverage and case information collected by the MOH and IGSS during the health fairs on the plantations. Project HOPE is planning to conduct workshops with its partners to share information about the joint achievements and barriers that have been encountered, as well as to strengthen the skills of the district-level partner agency staff in using the available data. A local epidemiological expert will assist in implementing this training activity.

C. In what areas of the program is technical assistance required?

The project continues to need some technical assistance for the area of reproductive health. The staff in charge of this component is very motivated and has conducted trainings together with local staff from JHPIEGO's MNH project. However, the technical capacity of the staff needs to be upgraded further.

Further assistance is required to conduct OR and other investigations to monitor and assess the impact of the project activities.

D. Describe any substantial changes from the program description and DIP that will require a modification to the Cooperative Agreement, and discuss the reasons for these changes.

As mentioned above, many of the coffee plantations are in flux due to the low world market prices of coffee. Many of the owners of coffee plantations are seeking to diversify their agricultural production. The presence of migrant families in the Boca Costa is also influenced by the low prices plantations can pay per quintal of coffee picked, the reduced need for coffee pickers, and new programs in the communities of origin of the migrants with new ways of generating income locally, reducing the need to seek seasonal employment. National policies of minimal wages make it difficult for the private employers to contract other laborers, because they cannot afford the labor costs. As a result, the project is considering to reduce the total number of plantation health units from 250 originally proposed to 200.

E. If specific information was requested at the DIP consultation for this program, please provide the information as requested. For each issue raised in the DIP consultation, provide a thorough discussion of how the program is addressing the issue.

The DIP was approved as presented, not requiring the submission of any additional information.

F. Describe the management systems that have been set up to ensure that the program runs smoothly, and include a discussion of any factors that have positively or negatively impacted the overall management of the program during the first year.

In Guatemala, the project receives technical oversight by the Country Director, Dr. Victor Calderon, the Deputy Director, Dr. Anabela Aragon, the field supervisor, and the administrator who support a team of pediatric and reproductive health specialists and community educators. The entire project team meets every two weeks to discuss progress, barriers and limitations.

Because Project HOPE is not the implementing agency, but provides support and facilitates the work of MOH, IGSS, Funrural, NGOs, plantation owners, and administrators, the team is in continuous communications with its partners at the departmental, municipal, and community levels. The HOPE team, under the daily oversight of the field supervisor provides follow-up and supervision to the activities of the partner agencies, and assists with the training and logistical support.

The CS project is also supported technically and administratively by the Project HOPE headquarters staff. Dr. Bettina Schwethelm provides overall technical guidance to the project. Virginia Lamprecht, reproductive Health Specialist, provides additional input on reproductive health issues. Bob Grabman, Regional Director, Michel Worthing, Assistant Regional Director, assist in daily administrative issue. Stuart Myers, Director of Finance and his team provide technical assistance on budget administration and monitoring of project expenses and grant compliance. The Guatemala project staff are in regular communication with HOPE center via e-mail, phone, fax, and site visits, and regularly share information and take joint decisions.

In addition to the headquarters team, Project HOPE has contracted a regional Health Education Specialist, Marta Arce. Ms. Arce resides in Peru, but spends much of her time providing onsite training to the projects in the Americas, as well as long-distance support. Ms Arce has a long professional background in education and adult teaching methodologies and is building training and education capacities in the region through the creation of standardize processes and approaches. Project HOPE Guatemala has also contracted a local education specialist whom works closely with Ms. Arce and provides the daily guidance and follow-up to the local training activities.

Factors that positively or negatively impacted program:

1. Financial management system – core elements in place, and those yet to be developed, including a timeframe, and “costing” exercises/training for program staff and partners

Project HOPE Guatemala's Administrator is responsible for monitoring the field budget. She submits monthly financial reports to the Financial Services Center for International Operations at HOPE Center and requests reimbursement to the imprest level. She can at any time request additional resources for special activities. The financial system functions very smoothly, and there is close and good coordination with the respective headquarters staff. All expenditures by local Project HOPE staff, as well as by staff of the partner agencies are documented with appropriate paperwork, allowing for excellent accountability and transparency of funds. The

attached project pipeline covering the months of September 30, 1997 – December 31, 2002 demonstrates expenses against the grant budget. The project is under-budget in the personnel category, since several key positions were filled late or were affected by staff turnover, which is being corrected by the field team.

The attached project pipeline combines CS XIII (September 30, 1997 - September 29, 2001 and its extension (Sept. 30, 2001-Sept. 29, 2005) together. For the Extension, the DIP Budget as presented to USAID March 2002, has been confirmed as the Revised Grant Budget. Grant spending is on track. Review of total spending revealed a discrepancy in the format of the two grants, the Extension does not separate Training costs as a separate line, and they are subsumed within “Other”. Originally, travel to attend Training events was planned as an expense to Travel, and only other ancillary costs of Training were to be charged to Training. Life of grant we find that Travel costs are being charged to Training directly. If we add the two lines together, total spending on Travel and Training is on target. Review has also revealed errors in coding on the part of the field office whereby Supplies and Equipment were charged to the grant rather than to the non-federal side, or Project HOPE. Project HOPE will work internally to move these costs to the correct fund source.

2. Human resources, lines of command developed, reporting and supervision, staff turnover

The organizational chart of the project can be found in attachment 3. The project has 25 staff members, most working full-time on project activities. The Country Director conducts monthly meetings with the staff to discuss project achievements, outputs, weaknesses, constraints encountered, and to problem-solve, make decisions, and address difficulties. The Deputy Director provides oversight to the day-to-day activities and meets with her staff every two weeks to review what has been achieved, make technical decisions, plan activities, and take corrective administrative or technical actions. She also spends some time in the field to directly monitor ongoing activities. The field supervisor spends 80% of his time in the field supervising the staff, and strengthening coordination and supervisory activities with the local partners at the various levels. The field staff works closely with the partner agencies, coffee plantations, and community volunteers. They also assist with training activities and provide follow-up and supervision to local partner and community volunteers. Logistical support is the responsibility of the administrative staff. All staff is required to submit monthly activity reports to their direct supervisor who shares this information with the Deputy Director and the Country Director. The project information is consolidated every three months and later analyzed with the partner agencies to determine how the project objectives are being achieved. Quarterly technical and administrative reports are also prepared for HOPE Center to allow technical and administrative staff to monitor project progress and share information with USAID and potential donors.

3. Communication system and team development

The HOPE Guatemala team keeps close communication amongst themselves as well as with HOPE Center and partner organizations. The HOPE country team has bi-monthly, monthly and quarterly meetings, which are used to discuss ongoing project activities as well as challenges

facing the project. The team also uses e-mail, fax, telephone and field visits to keep open communication lines with all those involved in the successful implementation of the project.

Direct communication with our partner organizations is made possible through bi-monthly meetings where activity reports are shared, as well as through its technical field staff on a daily basis.

In a recent evaluation of HOPE Guatemala's organizational capacity and leadership, communication was identified as one of the programs main strengths. HOPE Guatemala strives to identify programmatic strengths and weakness on a timely basis as to assure the success of the program.

4. Relationships with local partners, and tools used to facilitate these relationships

The relationship with the local partners is well established and maintained through regular work meetings, joint supervision visits, the participation of the Country Director and Deputy Director in the Health Area Council meetings at the department level, and the participation of Project HOPE staff in the MCH Commissions, which are workgroups under the Health Area Councils.

Overall, Project HOPE is valued highly as a partner, and this is expressed on many occasions, including that the MOH requests information about the migrant health activities from the districts in order to operationalize its migrant health program. This is also shown in that Project HOPE is continuously asked for technical assistance in the region. Project HOPE's IMCI and RH trainers are rates as excellent trainers and the Health Areas and IGSS regularly ask for their support in provider such training. HOPE staff has also been asked, and do participate, in national technical taskforces, and the opinion on the quality of training provided by Project HOPE is high at the national level.

5. PVO coordination/collaboration in country with other PVOs, USAID Mission, collaborating agencies, etc.

HOPE has a long history of coordination with local and international PVO at the national level. Amongst the ones who we are presently working with are: JHPIEGO, OPS/OMS, CARE, MOH, USAID Mission, International Labor Organization, the Order of Malta, and Aprofam (Asociacion Profamilia).

With JHPIEGO, HOPE provides technical assistance in improving the quality of the Basic Maternal/Neonatal Medical Attention (AMNE) as established by the Reproductive Health Program of the Ministry of Health. In this endeavor, HOPE also coordinates with other agencies such as OPS/OMS and Care.

For our Quality Health Project, HOPE is working with MOH in the IMCI and community-IMCI/AINMC Strategy. The project is responsible for assisting with capacity building, providing educational material and supplies for its implementation in priority areas.

HOPE and the USAID Mission hold a close relationship through Dr. Edward Scholl, Mission officer, who has participated in our program evaluations. HOPE is also a USAID member organization.

With financial aid received from the International Labor Organization, HOPE is developing the Child and Migrant Mother Health Initiative Program in the Coffee Plantations in four municipalities.

With the Order of Malta, HOPE is coordinating the distribution of donated powdered milk to breastfeeding mothers, pregnant women, and children under 12 years of age.

Aprofam and HOPE are coordinating capacity building activities aimed at community personnel.

6. If an organizational capacity assessment of any kind has been conducted during the LOP, including a financial or management audit, describe how the PVO/program has responded to the findings

With support from PACT (July 2002), Project HOPE Guatemala conducted an internal capacity assessment. This assessment has provided ample information about strengths and weaknesses in human resource management, administration, and technical capabilities. As part of the assessment process and continuing on, the staff developed an action plan (this plan is in Spanish and can be obtained in its entirety upon request from Project HOPE Guatemala).

The implementation of the Institutional Strengthening plan was put into effect in August of 2002. The plan outline three main objectives:

- Integration of HOPE's programs
- Increased productivity of human resources
- Increased administrative efficiency

For the first objective, the Guatemala office has been working on the standardization of monitoring formats, the strengthening of our relationship with partner organizations and present donors, as well as pursuing strategic and programmatic alliances that could develop into future funding sources.

The second objective is being achieved through the development of a Productivity Evaluation System, which has been in place since December 2002 with promising results. HOPE Guatemala has also conducted two motivational/exchange retreats to involve the personnel in the vision, mission, and strategic organizational objectives, as well as to strengthen personnel ties to the institution. At a smaller scale, HOPE has also conducted a motivational seminar emphasizing team building and personal identification with organizational and programmatic goals. Presently, HOPE is working on updating the institutional chart.

For 2003, HOPE plans to establish a standardized norms and procedures for the selection and hiring of future personnel as well as other needs in the creation of a Human Resource Management Manual as well as the updating of the existing Financial Administration Manual.

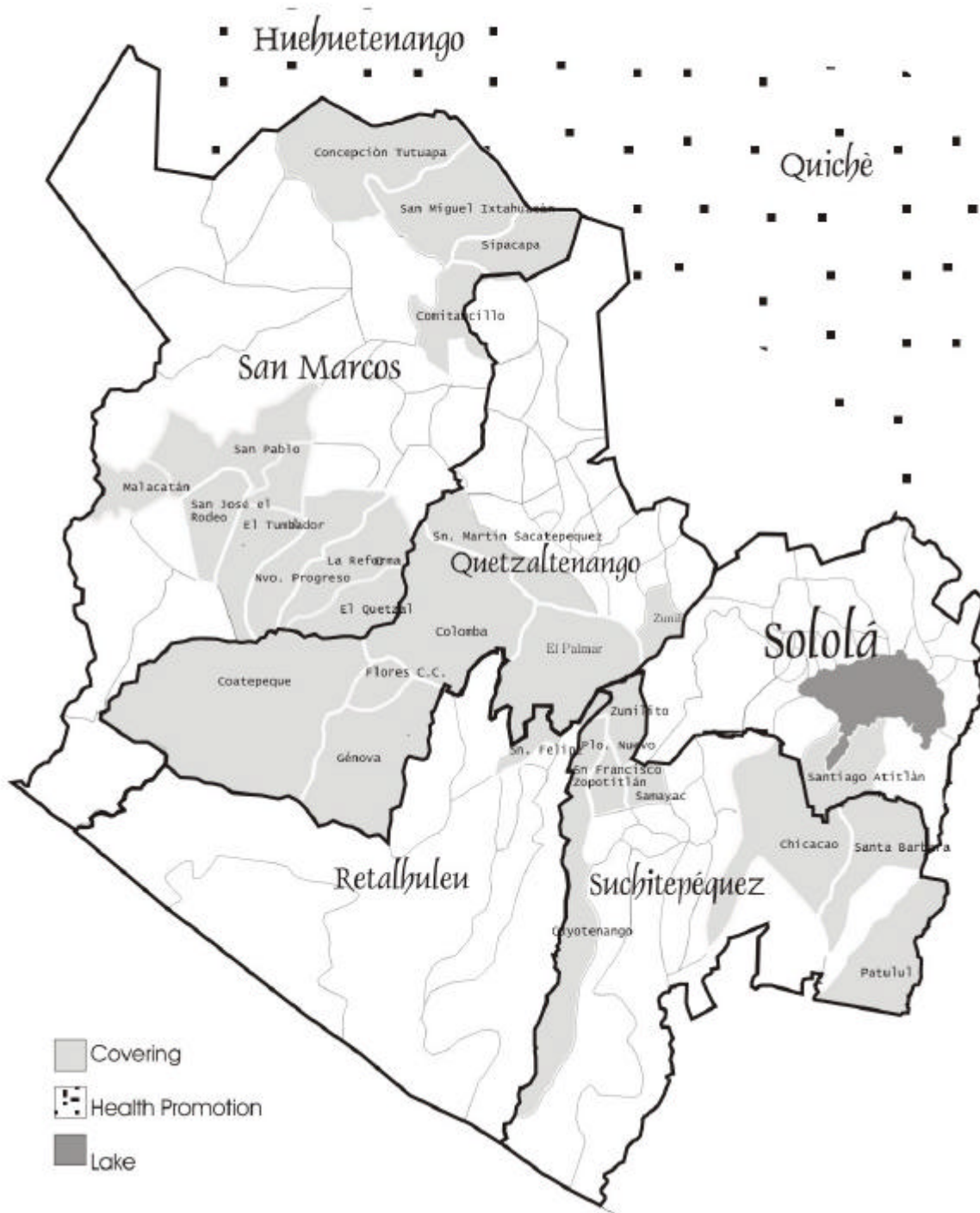
G. If a topic in these guidelines does not apply to the program, please indicate this in the Annual Report. If the program has not yet obtained sufficient information to fully describe an element, then please describe plans to obtain this information.

None Available.

H. Include in the Annual Report other relevant aspects of the program that may not be covered in these guidelines.

None Available.

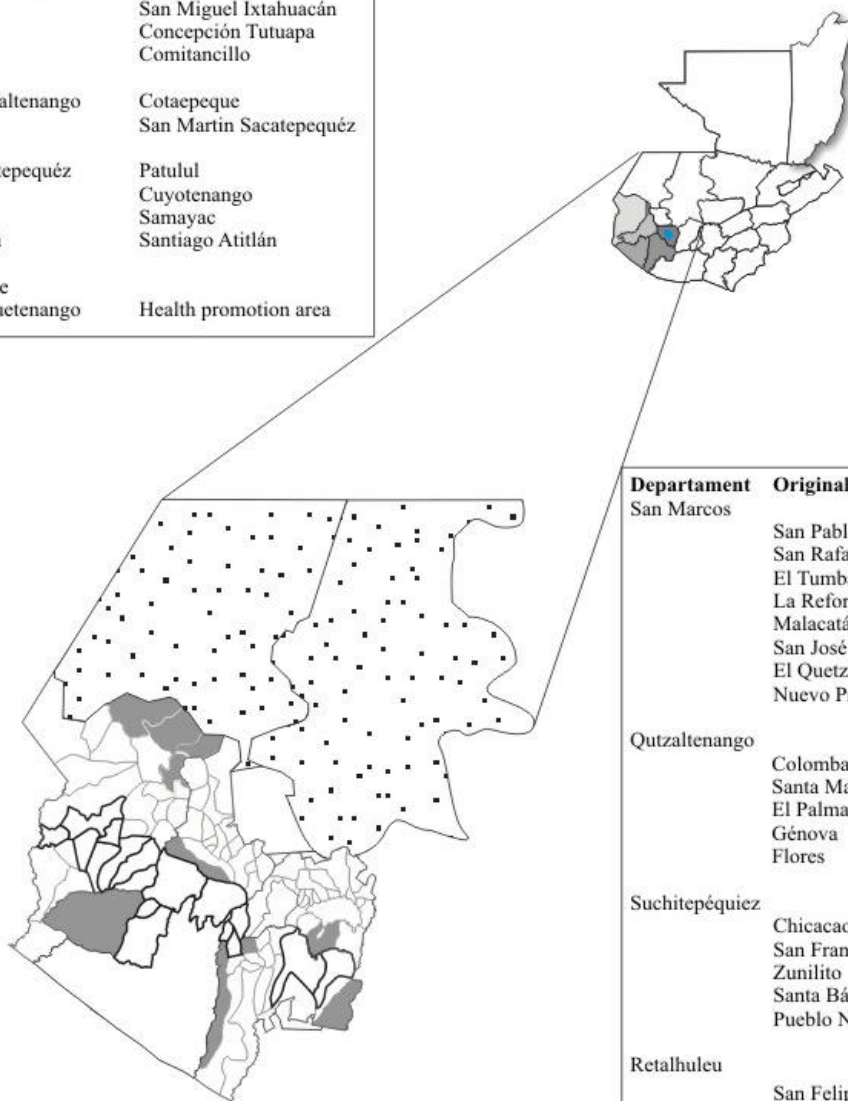
PLACING OF INFANTILE SURVIVAL PROGRAM PROJECT HOPE, GUATEMALA



REPUBLIC OF GUATEMALA

ORIGINAL AND EXTENDED MUNICIPALITIES

Departament	New Target Area
San Marcos	Sipacapa San Miguel Ixtahuacán Concepción Tutuapa Comitancillo
Quetzaltenango	Cotacpeque San Martin Sacatepequéz
Suchitepequéz	Patulul Cuyotenango Samayac
Sololá	Santiago Atitlán
Quiche	
Huehuetenango	Health promotion area



	Extended areas - residents and migrants
	Original areas - residents and migrants
	Health Promotion areas - migrant areas of origin

Departament	Original areas
San Marcos	San Pablo San Rafael El Tumbador La Reforma Malacatán San José El Rodeo El Quetzal Nuevo Progreso
Quetzaltenango	Colomba Santa Maria de Jesús El Palmar Génova Flores
Suchitepequiez	Chicacao San Francisco Zapotitlán Zunilito Santa Bárbara Pueblo Nuevo
Retalhuleu	San Felipe

Attachment 2: Training and Education Materials Used by CS-17 Project HOPE

1. IMCI/AINMC

PROGRAM COMPONENT	TITLE	PROVIDED BY	LEVEL OF USE
Integrated Case Management	Integrated case management protocols for children	MOH Calidad de Salud HOPE	Institutional
	Integrated case management protocols for women	MOH Calidad de Salud HOPE	Institutional
	Algorithm for children	MOH Calidad de Salud HOPE	Institutional
	Registration forms	MOH Calidad de Salud HOPE	Institutional
	Counseling sheets for the sick child	MOH Calidad de Salud HOPE	Institutional
	Family emergency plan	MOH Calidad de Salud HOPE	Institutional
	Community emergency plan	MOH Calidad de Salud HOPE	Institutional
	Referral forms	MOH Calidad de Salud HOPE	Institutional
	Growth chart with minimum expected weight gain	MOH Calidad de Salud HOPE	Institutional
	Videos on prevention of prevalent childhood illnesses	MOH Calidad de Salud HOPE	Institutional
	Child health card	MOH Calidad de Salud HOPE	Institutional
	Laminated counseling sheets for standard case management	MOH Calidad de Salud HOPE	Institutional
Prevention and Health Promotion	Counseling guides for child and maternal health	MOH Calidad de Salud HOPE	Institutional
	Reminder cards (advice for the family)	MOH Calidad de Salud HOPE	Institutional
	Register of children under two years	MOH Calidad de Salud HOPE	Institutional
	Monthly activity report of the vigilante de salud	MOH Calidad de Salud HOPE	Institutional

PROGRAM COMPONENT	TITLE	PROVIDED BY	LEVEL OF USE
	Weight gain summary sheet for children under two	MOH Calidad de Salud HOPE	Institutional
	Guide for the training of community volunteers	MOH Calidad de Salud HOPE	Institutional

2. Clinical IMCI Training Materials

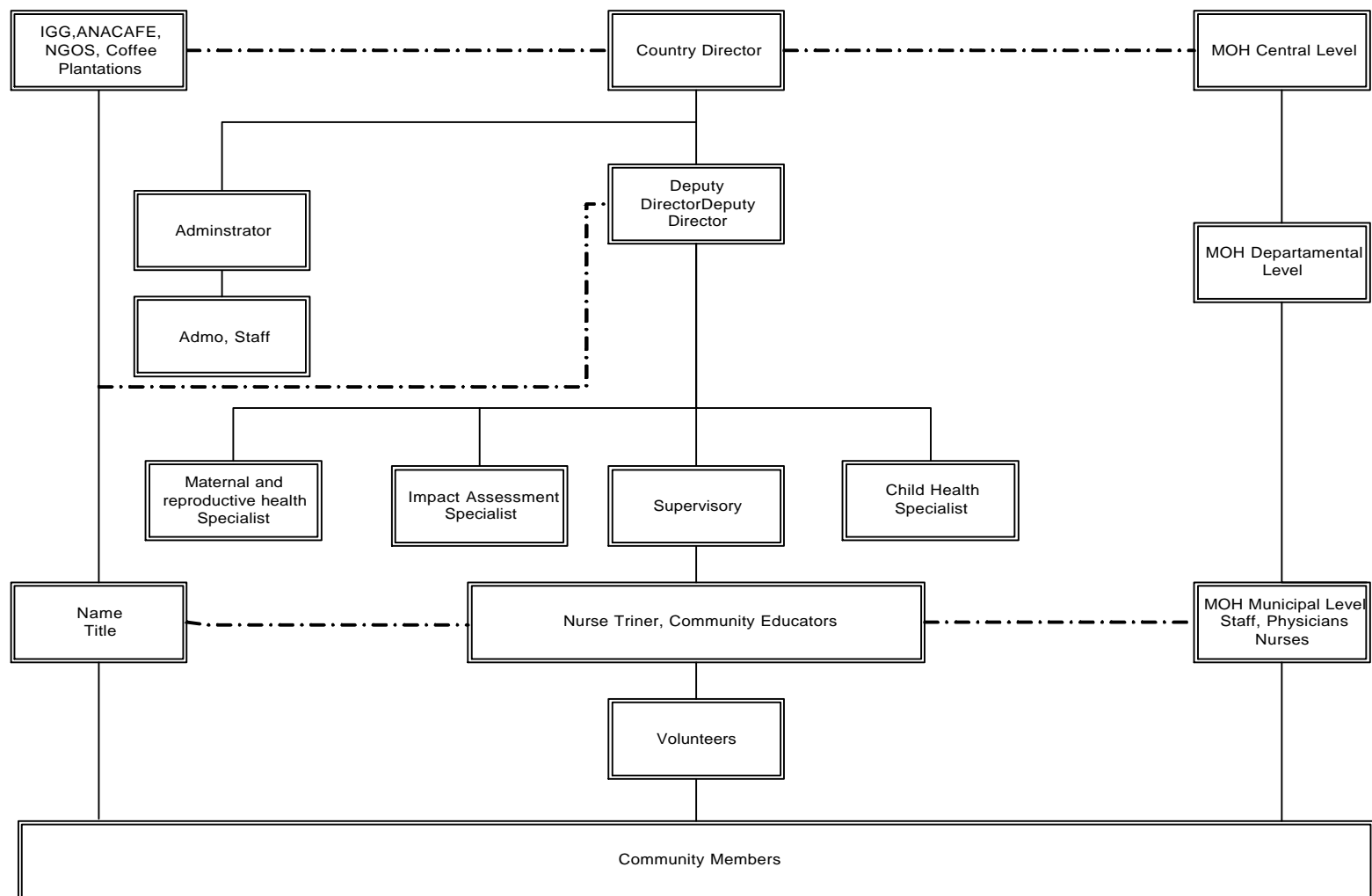
PROGRAM COMPONENT	TITLE	PROVIDED BY	LEVEL OF USE
Clinical IMCI Infections LRI Ear and Throat problems Diarrheal diseases Nutrition Immunization Fever Other problems	Methodology guide	MOH HOPE	Institutional
	Training modules (5)	MOH HOPE	Institutional
	Procedure manual	MOH HOPE	Institutional
	Basic techniques	PAHO/WHO UNICEF HOPE	Institutional
	Album of fotos	MOH HOPE	Institutional
	Videos of prevalent childhood illnesses	MOH HOPE	Institutional
	Algorithm in recording forms	MOH HOPE	Institutional
	Recording form for children under two months	MOH HOPE	Institutional
	Recording form for children 2 months to 5 years	MOH HOPE	Institutional

3. Reproductive Health Education Materials Used during the First Project Year

PROGRAM COMPONENT	TITLE	ORGANIZATION	LEVEL USED
Maternal and newborn care	IMPAC	MOH/RH Unit MNH Project/JHPIEGO	Institutional

PROGRAM COMPONENT	TITLE	ORGANIZATION	LEVEL USED
	Newborn resuscitation	MOH/RH Unit MNH Project/JHPIEGO	Volunteer
	Maternal danger signs	MOH/RH Unit MotherCare Project	Institutional and volunteer
	Guide for facilitators of TBAs Participatory teaching techniques Teaching manual <ul style="list-style-type: none"> ❑ Focused prenatal care ❑ Management of basic obstetric and newborn emergencies ❑ Facilitator package 	MOH/RH Unit MotherCare Project	Institutional
		MOH/RH Unit MNH HOPE/JHPIEGO	

Attachment 3: Functional Organizational Chart – Child Survival Program



Attachment 4: Project HOPE/Guatemala – Mothers Knowledge Study

Study Summary

Study was conducted on mother's knowledge after leaving their children's medical consult. It also measured long term practices and attitude; follow up appointments and treatment of children under 5 years of age on illnesses prevalent in the municipalities of El Tumbador, San Pablo, and Malacatan in the department of San Marcos, Guatemala for the year 2002.

Introduction

In Guatemala the IMCI strategy is a way of dealing with the problem of the illness and death of children under the age of five, through prevention (communication at the community level and educating the parents or adults responsible); diagnosis (strengthening existing knowledge and resolution) ; and treatment (donation of medicine and supplies).

It is necessary to maintain constant supervision and monitoring of the process, with the goal of reaching the objective or reducing the morbidity and mortality of children under five years of age, especially from pneumonia, diarrhea, and fevers.

The present study measured the mother's knowledge about their children's illnesses once they left the medical consult and their attitudes and practices seven days later. Its importance lies in that the mother needs to be conscious of their children's illnesses to be able to act accordingly. It also measures the level of knowledge given to the parents on follow up visits and reevaluation.

The study took place in the month of December 2002 in ten plantations and 3 health units in an adjacent community of migrants in the southern coast of San Marcos. The goal was to reorient or further educate to obtain the desired impact.

General Objective

To determine the mother's knowledge, attitudes and later practices once they leave the consult. The impact of the IMCI counseling in parents behavior in complying with the reevaluation and consequent follow up of children under five years of age.

Specific Objectives

- Establish the mothers knowledge once they leave the consult; attitudes and later practices
- Compare the institutional and community care level to the percentage of children under five years of age who are taken to a health center on a timely basis
- Determine why a child did not go to their follow up appointment
- Establish the danger to the child if they are not taken to their follow up appointment.

Methodology Design

Type of study: Transversal and Cohort study

Samples were selected in San Marcos department with the highest migrant population:

Tumbador - 4 plantations; San Pablo - 3 Plantations; Malacatan - 3 plantations.

Units of sample were children under the age of five.

We observed children five years of age and under that went to their follow-up appointment according to the norms established by the IMCI guidelines.

We interviewed the parents that fell under the morbidity category of the strategy once they left the consult and visited them seven days later. Health unit logs were updated, and groups of mothers with children with illnesses such as pneumonia, diarrhea, fevers among other illnesses included in the strategy were placed in-groups of 10 for services. Emphasis was placed on illnesses that require follow up visits. The cases presented were categorized according to their diagnosis and severity in accordance to the IMCI guidelines.

We determined the number of mothers that came back for their reevaluation and follow up.

It was also noted in how many cases that the mother never brought the child back for a follow up. In these cases, we made home visits to determine what type of care the mother or caretaker had given.

Results - Mother's knowledge once they left the consult and their practices after 7 days:

1. That the knowledge of the IMCI strategy once they left the consult was hardly changed according to the results.
2. If they are taken to the reevaluation consult on a timely basis, the difference in percentage of care given is not significant. The health centers are 44.8% compared to 53.3% at the health units making it the general return rate at 20%.
3. The interviewed group is between 25 and 34 years of age primarily female. 48% has no education and rest has only completed elementary level.
4. That the majority of children that are seen at the consults are over one year of age.
5. The mother or responsible adult in 100% of the cases remembers the diagnosis that the child is given.
6. That over 65% know what their child's illness is what treatment they need to have, for how long and how they have to give it. This knowledge decreases slightly after seven days.
7. The treatment is provided to them by the health centers in 90% of the cases
8. The general population knows that they need to give the child dehydrating salts in the recommended doses in 59% of the cases.
9. 68% know that they need to give the dehydrating salts for over two days.
10. Between 23 and 24 % of the population questioned knew that a sick child needed to increase their liquid intake.
11. 95 to 97 % of those interviewed did not understand why they needed to go back for a follow up visit with their sick child.
12. 78% did not know when they had to go back to the health unit for a follow up visit.
13. 41% once they left the consult did not know they had to return. Seven days later 75% did not remember they had to return.

Results of the consult reevaluation and treatment follow up:

Data of the adult responsible for the child

1. The group interviewed was between 25 and 34 years of age, predominately female and the mother, 32% belong to an indigenous group and 64% to the Ladina group. 48% has no education and 54% has only completed elementary level.

General data of the child

1. 78% of the children seen were between the ages of one and five years of age. The mother's knowledge of their child's illness corresponds to those given by the health center.

2. That in 96% of the cases the medicine was supplied by the health center (health center, health unit, and health post)

3. That 100% of the mothers/adults gave the child the medicine although not in all cases was the doses completed (only 43.2% understood for how long they had to give the medicine) or given at the appropriate times. 17.8% of the responsible adult ignored the directions completely.

4. 81% say to have finished the medicine

5. That out of 43% of diarrhea cases, only 25% were treated with dehydrating salts making it only 52%.

6. 16.8% of those interviewed know that the child ill with diarrhea needs more liquid, food or milk (breast milk).

Data about the reevaluation and follow up consult

1. 73% of those interviews said they did not know when to go back for their follow up visit

2. Only 20.4% went back with the sick child for a reevaluation

3. 85.4% said that the child was already well and did not need a follow up.

General Conclusions

- The present study was transversal and cohort, for convenience purposes thus cannot be globalize to represent the rest of the services.
- That the mothers or responsible adults have has similar knowledge of their child's illness when they leave the consult as they have seven days later.
- That there is not much difference between the services rendered at the health center and the promoters

- That 94% of the mothers that felt their child was already better did not take them to their follow up appointment. It is valid to point out that out of this group two of the children died and 2 had to be medicated.
- That the treatments were almost totally administered by the health services
- That more than 65% of the mothers knew how, when and for how long to give their child the medicine; but as soon as they felt the child got better they stopped giving it.
- That in 75% of the cases, once the child was ill, they stopped feeding him/her or giving them liquids.
- That diarrhea is not treated properly in 50% of the cases since dehydrating salts and their intake explanation were not provided.
- That the mother's educational component is deficient in explaining what needs to be done in order for the treatment to be effective, the warning signs, and when and why to return for a follow up.
- The impact of the IMCI reevaluation counseling is weak since only 20% returned for a follow up.

Recommendations

- Analyze the data obtained in conjunction with the health centers.
- Results will be shared with the Ministry of Health of San Marcos, so that the different institutions that work in that department can draw from its results and develop programs to improve it.
- Health education should continue as a programmatic priority area of the program
- Rewrite the health guides of procedure of educating parents to include way to transmit the message, its reception and absorption.
- Continue to provide the IMCI training to all health personnel, with supervision and monitoring of its results
- It is important to always include the participation of the health promoters and community health volunteers. A good training and monitoring system must be set in place so that the service given is reflected on their knowledge.
- Implement with the help of the health sectors a training supervisory operative.

Attachment 5: Budget Pipeline
